Better Value Workgroup

Wednesday, August 26th 2015 - 2:00 p.m. – 5:00 p.m.
West Virginia University Health Sciences Center – Charleston, WV

MEETING SUMMARY NOTES

Today's Expected Results:

- Provide recommendations for the design of a system that delivers coordinated care
- Identify next steps, materials and expertise needed for our next session, unresolved issues regarding obesity, the related system of coordinated care and prepare for September's meeting
- Strengthen working relationships among workgroup members

Co-Chairs: Jeremiah Samples and Jeff Wiseman

Facilitator: Becky King

Participants: 41 people - 33 in person and 8 electronically

TOPIC	OVERVIEW/DISCUSSION/DECISIONS
Welcome, Introductions and Opening Remarks	The second SIM Better Value Workgroup meeting opened with welcoming remarks. Joshua Austin, SIM Project Coordinator, was recognized for his role as liaison between all workgroups. The agenda with expected results for the meeting and ground rules were reviewed with workgroup members.
Recap of July Workgroup Meeting Results	Mr. Austin shared a PowerPoint presentation with the workgroup to highlight the workgroup summary report process and key themes from the initial SIM workgroup meetings held in July. Key results from all five workgroups were put into a SOAR Chart; one main point from each section was highlighted. **Strengths:** Engaged, well-connected health care stakeholders **Opportunities**: Adopting a value-based approach to health care payment at the federal level encourages / requires change(s) at the state level **Aspirations:** Movement from a fatalistic attitude to one that places a high priority on health and wellness **Results**: Standardize and align health care quality measures among all payors and providers The Better Value July Survey Results, "Minority / Non-Attendee Report" and the July Better Value Meeting Summary were included in participant packets and highlighted by Mr. Austin. Key takeaways from the July Survey Results included: • High-level consensus scores around aligning measures; determining the return on investment of measures; integrating physical, behavioral health and dental care and agreement for a model that includes care coordination • Low-level consensus scores around issues such as movement toward a fully-capitated model and movement toward a single-payor system In response to workgroup member questions, Mr. Austin clarified that results regarding a single-payor system were not biased given the number and diversity of survey responses. Additionally, it was reiterated that changes to current Centers for Medicare and Medicaid rules / federal law are not allowed under the SIM grant, as described in the "Mutual Understandings and Assumptions" document distributed in July. However, opportunities for funding innovative changes and best practices may be available in the future.

The State of Obesity in West Virginia	Jessica Wright from the DHHR Bureau for Public Health, Division of Health Promotion and Chronic Disease provided an informative PowerPoint presentation on the state of obesity in West Virginia. The presentation outlined the specifics of the obesity plan section of the State Health Improvement Plan. Q&A followed the presentation.
Overview of Designing an Alternative Payment Model for Better Value in West Virginia: Small Group Discussion and Reports	To set the stage for small group discussion and feedback, Jeremiah Samples, DHHR Deputy Secretary, highlighted a starting point document, which includes three critical system alignment components: a Medical Home, a Medical Neighborhood and a Regional Care Collaborative (RCC). Mr. Samples also explained the four goals for the SIM grant as established by the SIM Steering Committee. 1. Establish a highly coordinated care delivery system built upon a comprehensive primary care model; 2. Implement payment systems developed to enhance value for consumers; 3. Adopt population health improvement strategies that address existing health disparities, modifiable risk factors and preventable conditions and 4. Expand the use of information technologies to provide better intelligence to providers and other stakeholders. The document also included a supporting hypothetical vignette. It was noted that the document was updated and revised following the Better Care and Workforce Development Workgroup meetings held earlier in August. **First Small Group Discussion and Feedback Session** As part of the first small group discussion session, participants responded to the focus question: ***Are there any modifications needed to the model components to better meet the goals (listed above)?*** Small group reports, including key questions, are provided below. **The responses below have been edited for clarity.** • Behavioral health should be coordinated and specifically integrated into the medical home component

	• Provide support for federally qualified health centers to expand primary care to "build out" the Medical Neighborhood • Improvement of care coordination in smaller providers • Incentive payments for meeting targets is a good thing, but reporting standardized data should be fundamental to the model • There is concern that the Regional Care Collaboratives (RCCs) may establish their own assessment criteria / measurements for success • The model does not contemplate changing outcomes based on the level of risk per region (e.g., based on social determinants of health) • A state agency or entity may offer provider planning, technical assistance and other support, but it is unclear who regulates or controls the RCCS • The model does not offer transparency of costs for review by consumers • Unsure if it is possible to establish pilot programs under the auspices of RCCs • Provider and patients should make decisions about treatment, not third parties • An EHR across systems is good for sharing data • A global payment could assist providers in driving down costs • It would be helpful to see the regional breakdowns for the RCCs • West Virginia's current health infrastructure could easily evolve into this model • The RCCs may add to administrative costs • This model facilitates being phased in for purpose of full implementation • This model requires a more comprehensive / holistic care model that requires long-term and sustainable change • This model moves toward a more team-based approach to health care, which is different from the current system in West Virginia • To transition to this type of model, funds are needed to support transformation – presents the Chicken or the Egg Problem • West Virginia currently lacks the capacity to deliver these types of services in certain regions • The challenge of the current insurance model is that it creates a disconnect with patient health incentives and provider delivery; volume, not health is the focus

	• There is concern about the patient / provider ceding control to a region when that control was once localized • Redirect focus on the positive aspects of health and wellness instead of pointing out and emphasizing negative health behaviors – use motivational interviewing, professionals to redirect focus • This model appears to be an attempt at using a comprehensive holistic model instead of simply a medical model • There will need to be a significant shift in the system to help physicians better treat patients and put control into Medical Neighborhoods or regions **Questions that were raised during discussion of the model included:** • How would specialized care look in our state under this model? • What is included in "virtual care?" • What is a good example of a Medical Neighborhood, and what does it entail? • What does it mean to have a statewide health coordinated structure, and who will pay for it? • Is an RCC a state or regional agency? A non-profit entity? A for-profit entity? • Reduce cost shift – should there be a negotiated rate for defined populations (i.e., pilot project)? • What are the incentives for providers to participate and improve? • How will standardized measures for payment be set? • Who governs / creates the RCCs? (guarding against excess capacity and lack of capacity) • What is the role of hospitals? Are there any incentives for hospitals? • What are the regions for the model? • How does data flow across entities if there is no connection or contractual relationship? • How do entities mitigate liability from using WVHIN, or for a data breach? • Need to define: what care coordinators will do, and how they will do it. • Need to define: who or what is the RCC. • How does the infrastructure of a RCC pay for itself? • How do you expand primary care to include health coaches, community care workers, etc.?

	Second Small Group Discussion and Feedback Session As part of the second small group discussion session, participants discussed and addressed two focus questions regarding the model structure from a payment perspective. Small group reports are provided below. **The responses below have been edited for clarity.** **1. From a payment perspective, what are the questions we need to address about the model structure (e.g., medical home built into a medical neighborhood within a RCC) for this new delivery system?** • Until the care deliverers are responsible to state the payment required for services, the model will not be successful – moving from fee for service to a distributed risk model at patient, provider levels • It is possible to adjust the system in terms of reimbursement by 1. creating codes that are non-physician driven to allow for health coaches and other similar professionals or 2. PEIA model – capitation-based rate that is comprehensive • Uniformity / commonality in what is paid and to whom for care coordination services • Who coordinates the coordinator activities? • Unsure how RCCs should be arranged • Concerned about the level of patient / provider choice in the system • Will there be transparency of price / quality to help consumers decide which system they want to use? • What will be measured: process, outcomes or both? • How should transitions occur from the current system to future models? • What happens to smaller hospitals financially? • Who determines how different providers participate in the RCC or Medical Neighborhood? • How do we prevent high-cost patients from being removed from the system? • How is risk for populations determined? Who sets risk tiers? • Can managed care organizations / insurance entities cover risk in RCCs?

	2. From a payment perspective, what questions regarding a care coordination model must be resolved? (Ex. Who employs the care coordinator? How are care coordinators compensated? etc.) • How do we create a path to achieve this proposed model without destroying the present health care system? • How do we get to a payment system that is actually based on cost, delivery and quality of care? • Where is the best place to house care coordinators, and the most effective place to have care coordination? • Within the primary care facility / medical home environment, there is significant need for more than one care coordinator; there must be a team of coordinators, which would help move away from the 15-minute office appointment • The increased use of telemedicine / virtual care coordination • Identifying where current care coordinators are in West Virginia, and what would assist them to improve their care services and / or help expand their current practices • Senior care needs coordination, especially with long-term care costs • What is the size of RCCs? Is the size based on risk? • Will RCCs include non-health care participants / organizations? • How will cooperation among regions work? • How does coordination of RCCs work? • Is there a certification process for RCCs? • How do we ensure care coordination is tied to outcomes? • Who do you incentive and how? Examples: per claim v. per episode v. coordination • Is it top down (RCC) or bottom up (Medical Home) based? • What is the definition of a care coordinator? • Will RCCs develop their own mission, values statements? • Should RCCs be non-profit and mission-based or for-profit? • Who will pay for care coordination? • How are care coordinators paid? Are they paid differently among regions? • A portion of care coordinators should be social workers

	• Care coordinators need access to medical and social service data. How do they get it? • Who employs the care coordinator? • How will decisions be made around care coordination accountability? • There is a concern about accountability and the penalizing of providers for non-compliant patients; there needs to be some sort of process to address non-compliant patients
Next Steps, Action Items and Assignments	• A post-meeting survey will be sent to all Better Value Workgroup members. • Members are encouraged to e-mail any additional questions regarding the State Obesity Plan to Mr. Austin at jaustin3@hsc.wvu.edu. • Research on other state models and technical assistance resources will be identified to address key questions raised about the model design components. • **The SIM Better Value Workgroup will reconvene on Wednesday, September 16, 9:00 a.m. – Noon at the Thomas Memorial Hospital Education Center in South Charleston, West Virginia.**
Parking Lot	None

Group Checkout (Verbatim Responses)

What worked well today?	***What would you change for the next meeting?***
• Diversity of groups and fields represented • Pre-meeting materials and preparation • Stimulating discussion • Lots of good ideas shared • Pros and cons of ideas were well discussed • Good group discussion • Hypothetical vignette was a good place to start for getting lots of feedback • Everything was run very well • Good dialog • Brainstorming of ideas • Small group discussions and reports	• Parking and building access • Topic was too broad to get very far • Would have benefitted from guidance – targeted questions – or split subject matter in more than one session • Does not appear to be much consensus within small groups or among all small groups • Lots of questions; no answers • In the end, it comes down to who pays and how is the money distributed. This is critical. • No complaints • Create more time for dialogue on groups comments

• Jessica Wright's presentation – outstanding • Information was good as participation • Great questions raised • Good leadership for questions / breakouts • Small group discussion • Not moving into different groups • Thought provoking questions • I believe the breakout and reporting out exercises worked well, better than expected • Good group of people to share ideas • The small group exercises were good to stimulate what questions need to be answered • Most groups came up with (very good) questions to be decided. That's OK IF we have the opportunity later to address answers	• Maybe only one breakout with small groups having more time • The questions were vague, especially since we didn't get the model until the afternoon before • More questions than answers • More focus for breakouts so groups don't drift so much • Providers are needed at the table – Doctors practicing are missing • Parking and room dynamics • Explanation of concepts • It would be helpful to receive the substantive materials 48-72 hours ahead of the meeting in order to be able to put more thought into the output • Going forward in terms of medical home and medical neighborhood model, it seems important to review in detail with the broader SIM group 2 or 3 existing models and strengths and weaknesses • Explore differences between ACO model and collaborative medical neighborhood • In terms of obesity, not enough discussion how cultural change would occur • Need more direction at the top of each session to determine questions group is to answer • Not clear what the questions and models were asking

Additional Comments

- How will telehealth integrate into the model?